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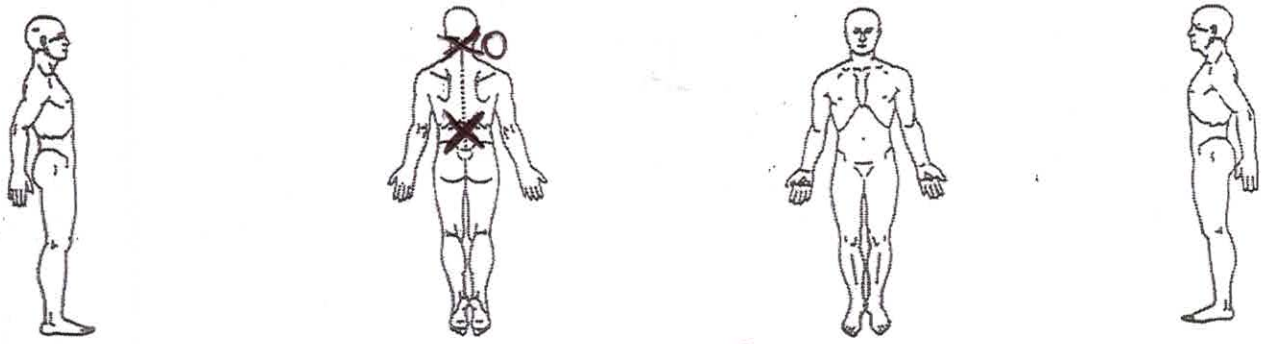
Massage Therapy Case History Form

Patient Name: MARK BISHOP Gender: (Male) Female Date of Birth: 14/3/1959
Address: 20 MARLBOROUGH ST LONGFORD Occupation: CAFE OWNER
Phone: (Home) _____ (Work) _____ (Mobile) 0409236186 (Email) _____
Are you in a Health Fund? YES If yes, which one? BUPA Previous Massage? YES
What is the main reason for your visit? NECK / BACK PAIN / VERTIGO

Please locate on the diagrams below: X for pain; O for stiffness; N for numbness



Please rate the pain on a scale of 0 (no pain) to 10 (extreme pain): 3
Any allergies? YES NO If so, what? NO
Any contact lenses, prosthetic devices, dentures or pacemaker? (YES) NO Any chance of you being pregnant? YES (NO)
Are you currently seeing a medical doctor, chiropractor, osteopath or any other health care practitioner? (YES) NO
If so, for what condition(s)? VERTIGO
Taking any medication? (YES) NO What for? BLOOD PRESSURE / CHOLESTEROL

Whilst massage therapy is very beneficial, it may sometimes not be appropriate, or it may need to be modified to best suit your needs and state of health. Please circle Yes or No to all the listed conditions listed below and if you currently have or had any of the following in the past, please provide details under Comments below:

		Comments			Comments
Headache	(Y) N		Indigestion	Y (N)	
Head Injury/Concussion	Y (N)		Nausea/Vomiting	Y (N)	
Seizures	Y (N)		Diarrhoea	Y (N)	
Vision Disturbance	Y (N)		Varicose Veins	Y (N)	
Ear Infection/Pain	Y (N)		Malnutrition/Weight Loss	Y (N)	
Inflammation	Y (N)		Infectious Diseases	Y (N)	
Any form of cancer	Y (N)		Skin Condition	Y (N)	
Chest Pain	Y (N)		Fracture(s)	Y (N)	
Breathing Problems	(Y) N		Diabetes	Y (N)	
Asthma	Y (N)		Sprain/bruises	Y (N)	
Tuberculosis	Y (N)		Fever	Y (N)	
Heart Problems	Y (N)		Tetanus	Y (N)	
High Blood Pressure	(Y) N		Any undiagnosed pain	Y (N)	
Back Pain	(Y) N		Past/Scheduled Surgery	(Y) N	DEVIATED SEPTEM
Shoulder/Hip/Knee Pain	(Y) N		Other	Y N	

I, (PRINT NAME) MARK BISHOP **declare that all the answers and statements above are true and complete. I have stated all my known medical conditions and take it upon myself to keep the Massage Therapist updated on my health during any subsequent treatments.**
There is a missed appointment fee equal to your consultation fee for any missed or cancelled appointments with less than 24 hours' notice.

Signature: _____ **Date:** 23/11/23